General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bourne Road Pharmacy, 7 Bourne Parade, Bourne Road, BEXLEY, Kent, DA5 1LQ

Pharmacy reference: 1032632

Type of pharmacy: Community

Date of inspection: 02/10/2019

Pharmacy context

The pharmacy is located on a parade of shops surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 75% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations and blood pressure checks. It supplies medication in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not always ensure that team are undergoing training appropriate for their role. And this means that they may not have the skills or knowledge they need to provide the pharmacy's services safely.
3. Premises	Standards not all met	3.5	Standard not met	The pharmacy does not keep the floor in the dispensary clear from tripping hazards and this could increase the risk for team members. And the consultation room is not suitable for the services offered. It is cluttered and not maintained to a level of cleanliness expected.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have an adequate date-checking routine and it does not always keep medicines in containers which are properly labelled. This may increase the risk that date checks or product recalls are not dealt with effectively. And could increase the risk of people getting medicine which is past its 'use-by date'. The pharmacy does not store medicines which need cold storage properly. And this increases the risk that these medicines are not safe for people to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy adequately identifies and manages the risks associated with its services. It regularly seeks feedback from people who use the pharmacy and team members understand their role in protecting vulnerable people. The pharmacy largely protects people's personal information. And it generally keeps its records up to date and accurate.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with its activities. Documented standard operating procedures (SOPs) were available, but there was no date of preparation on them and the details of who had prepared them were missing. Team members had not signed to indicate that they had read and understood these. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. A near miss log had been used recently in August 2019 but there had only been six entries made in the past year. And the last review was carried out over a year ago. There were three different strengths of the same medicine were kept in one stack. Medicines in similar packaging or with similar names were not generally separated. The pharmacist said that he was not aware of any dispensing incidents. He was not sure where previous records were kept and he confirmed that he would find an incident form and complete it if he was informed about a dispensing incident.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The trainee dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. She confirmed that she would not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The responsible pharmacist (RP) log was completed correctly and the correct RP notice was clearly displayed. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacist said that the Patient Group Direction for the influenza vaccination was held at another pharmacy within the organisation. He said that he would ensure that a copy was kept at the pharmacy in future. The team members could not locate the paperwork to show that relevant information was recorded when an unlicensed medicine was supplied. The pharmacist said that he would ensure that these were available in future. The nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The private prescription record was largely completed correctly. But the prescriber's details and the patient's address were not routinely recorded. There were several private prescriptions that did not have the required information on them when the supply was made. The pharmacist said that he would ensure that this information was checked in future.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Bagged items waiting collection could not be viewed by people using the pharmacy. A smartcard used to access the NHS spine had been left in the docking station overnight. It belonged to the regular pharmacist who was not working at the pharmacy on the day of the inspection. The trainee dispenser removed the smartcard and replaced it with her own. Two of the team members had put their personal identification number on their smartcards, these were removed by the pharmacist when prompted by the inspector.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website and a copy was kept in the pharmacy. The comfort and convenience of the waiting area had been highlighted as an area for improvement, but this had not been improved since the survey was completed. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members said that they had completed some safeguarding training, but not while working at the pharmacy. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough team members to provide its services safely. But it does not always ensure that team members are enrolled on approved pharmacy courses within the required time frame. This could mean that they do not have all the skills and knowledge they need to undertake their tasks safely. They can raise any concerns or make suggestions. But they are not always provided with regular ongoing training. This could make it harder for them to keep their skills and knowledge up-to-date.

Inspector's evidence

There was one pharmacist and two trainee dispensers working during the inspection. One dispenser had worked at the pharmacy for around two months. The second dispenser had worked in the pharmacy for around eight months and had qualified as a pharmacist in India. She was not enrolled on an accredited pharmacy course, but she said that she had given her details to the pharmacy's head office the day before the inspection and was due to be enrolled on a course. The pharmacist was not able to confirm during the inspection that the second dispenser had been enrolled on the course. A trained dispenser started work towards the end of the inspection. She said that she had completed an accredited dispenser course with another pharmacy.

The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The trainee dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products and knew the reason. She confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the Continuing Professional Development requirement for the professional revalidation process. He said that he had recently completed training in preparation for the travel clinic and influenza vaccination services. During the inspection a team member presented the pharmacist with a labelled box of tablets to check, but he did not check this against the prescription or sign the label before handing it out. The inspector reminded him of the importance of checking the medicines against the original prescription to help minimise the chance of mistakes. He said that he would carry out a thorough three-way check in future.

The pharmacist said that team members were not provided with any ongoing training. He said that he planned to start some training with them in the new year. He confirmed that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members said that they felt comfortable about discussing any issues with the pharmacist or any concerns. The trainee dispenser said that he also worked at another pharmacy within the organisation and was due to have an appraisal and performance review but people had been on leave so this had not been done yet.

Targets were not set for team members. The pharmacist said that services were provided for the benefit of the people using the pharmacy.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not keep all its work areas appropriately clean and tidy for the services it offers. It administers vaccinations in the consultation room, and it does not keep the room in a suitable state for this service. It does not keep the floor in the dispensary clear from tripping hazards and this could increase the risk for team members. The pharmacy keeps its premises secured from unauthorised access.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright and clean. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air-conditioning was available; the room temperature was suitable for storing medicines.

A room upstairs was used to store a variety of items, including expired medicines and uncollected multi-compartment compliance packs. Some of the packs had been assembled in 2014. The pharmacist said that he was waiting for a mock inspection to be carried out to inform him what to do with many of the issues in the pharmacy, including that room. There were several medicines kept on the floor in the dispensary. Some were in baskets or delivery boxes but others were directly on the floor. A delivery box in the dispensary posed a tripping hazard for team members and one of the team caught her ankle on it during the inspection.

There was a small padded bench in the shop area and the cover was worn. This was positioned near to the medicines counter and conversations at the counter could clearly be heard. The consultation room was not accessible to wheelchair users. The door to the shop area had been blocked with product stands and the other door was to the side of the medicines counter. The room was cluttered with boxes and other items and did not present a professional image. The window in the door to the dispensary was not covered and this may pose an issue if someone needed to remove an item of clothing. Low-level conversations in the consultation room could not be heard from the shop area. The pharmacist said that vaccinations were administered in the room. But the room was not maintained to a suitable level of cleanliness for the services offered.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services **Standards not all met**

Summary findings

Overall, the pharmacy manages most of its services in an acceptable manner. But it does not have an adequate date-checking routine and it does not always keep medicines in containers which are properly labelled. This may mean that it is harder for it to take appropriate action when there is a medicine recall or alert. It does not ensure that medicines that need cold storage are kept in the proper conditions. And this increases the risk that these medicines are not safe for people to use. People with a range of needs can access the pharmacy's services. And it gets its medicines from reputable suppliers. The pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets were available.

Prescriptions for higher-risk medicines such as methotrexate and warfarin were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. Although, the trainee dispenser knew how long these prescriptions were valid for. The pharmacist said that he would ensure that prescriptions for higher-risk medicines and Schedule 3 and 3 CDs were highlighted in future. The trainee dispenser said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy did not the have the relevant patient information leaflets or warning cards available. The trainee dispenser said that she would order some from the manufacturer.

Stock was mostly stored in an organised manner in the dispensary. The pharmacist said that expiry dates were checked every three months, but this activity had not been recorded since December 2018. Some short-dated items had been marked but this was not consistent throughout. There were several out-of-date items found with dispensing stock, one of which had expired in June 2019. Several medicines were found which were not kept in their original packaging and many boxes found contained mixed batches. Some of the packs did not include all the required information on the container such as batch numbers or expiry dates. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The pharmacist removed the items found by the inspector and placed these for disposal.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. But the thermometer on the day of the inspection was showing a maximum temperature of 27.9 degrees Celsius and a minimum temperature of -6.1 degrees Celsius. The current temperature was at 15.8 degrees Celsius or 5.5 degrees Celsius depending on which dial on the thermometer was checked. The pharmacist said that he had checked the thermometer on the day of the inspection. But when asked by the inspector, he was not sure how to reset it. The inspector showed him how to do this and suggested that he monitor the temperature. The fridge was a domestic variety and there was mould and ice on

the inside back wall. The fridge was fully stocked and medicines had been touching the back wall. Some packaging was wet and some had ice on.

The trainee dispenser said that part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. But prescriptions were not always kept at the pharmacy until the remainder was dispensed. This could make it harder for team members to refer to the original prescription and could potentially increase the chance of errors. The trainee dispenser said that uncollected prescriptions were checked every two weeks and any which remained uncollected after around three months were returned to dispensing stock where possible. There were several prescriptions in the retrieval system which had expired and some items waiting collection did not have the prescription attached. The pharmacist said that uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The trainee dispenser said that people had assessments carried out by their GP if they requested to have their medicines dispensed into multi-compartment compliance packs. Prescriptions for people receiving these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people usually contacted the pharmacy when they needed them. The pharmacy kept a record for each person which included any changes to their medication. Packs were suitably labelled, but there was no audit trail to show who had dispensed and checked each tray. This could make it harder for the pharmacy to identify who had done these tasks and limit the opportunities to learn from any mistakes. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people have up-to-date information about how to take their medicines safely. Warnings and cautionary advisory were not recorded on the backing sheet, one of the trainee dispensers showed the other how to make sure that these were printed on the backing sheets.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacist said that the driver obtained people's signatures for deliveries where possible. He said that the driver worked for a few pharmacies and he had the delivery sheets with him. He showed the inspector some delivery sheets from 2011 to 2016 and there were multiple people's details on each sheet. He confirmed that he would ensure that other people's personal information was protected when signatures were obtained in future. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist showed the inspector a folder containing some drug alerts and recalls. There were two from January 2018 and ones prior to that were from 2014 and earlier. The inspector found that some drug alerts and recalls received from the MHRA via email had been opened. The pharmacist said that these had been actioned, but no record of any action taken was kept, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would ensure that records were kept in future.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it

was not yet being used. The pharmacist said that team members were waiting for training to be provided by an external organisation and this was due to be carried out soon.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Equipment for measuring medicines was available but not for volumes less than ten millilitres. The trainee dispenser said that team members used plastic oral syringes to measure small amounts. The pharmacist said that he would order suitable measures. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for around four months. The shredder was in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.